



Delta Dental of Tennessee
 240 Venture Circle
 Nashville, TN 37228-1699



EMPLOYEE/RETIREE ENROLLMENT AND CHANGE FORM

- New Enrollment
- Change
- Open Enrollment

Sublocation Number

- 0001 – Active
- 0003 - Retirees

Group Name/ Group Number
 Shelby County Government/5319

SOCIAL SECURITY NUMBER (must be 9 digits)		
FIRST NAME		
LAST NAME		
STREET ADDRESS		
CITY	STATE	ZIP

Birth Date	Sex	Hire Date	Work/Home Number	Department	Effective Date (Do not Complete-Benefits Use Only)
	M <input type="checkbox"/>	F <input type="checkbox"/>			

If enrolling OR dropping spouse and/or dependents please list them below and check appropriate box. Attach another form for additional dependents.

FIRST NAME & M.I. (LAST NAME IF DIFFERENT)	Birth Date	Sex		Check One		Effective Date (Do not Complete-Benefits Use Only)
		M	F	Add	Drop	
SPOUSE:						
CHILD:						
CHILD:						
CHILD:						
CHILD:						
CHILD:						

Based on the above change, new coverage is: EE EE+1 FAMILY

Cancel Coverage (ONLY CHECK IF CANCELING YOUR ENTIRE DENTAL PLAN) Cancel Date: _____

CHANGE NAME From: _____ To: _____

CHANGE ADDRESS To: _____

I agree to complete proper forms and provide proof of relationship (i.e. birth certificate, marriage license, etc.) to add/delete eligible or ineligible dependents, as required. I agree to make the required contribution. I certify that the information contained in this form is true and correct to the best of my ability.

Signature: _____ Date: _____

For Office Use Only	EIN:	Entered By:	Comments	DDPT – Shelby Co Gov (10/12)